3 Year Old AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam:
OD _____
OS _____
OU _____
Corrected / uncorrected

Temp: _____
Pulse: _____
Resp: _____
BP _____
BP Elevated?

Dental Screen: Date of last exam: _____ Routine: ____ Urgent: ____ Parent advised: ____ Brushing child's teeth? Yes ___ No ___

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits? (ABR, OAE): Yes ____ No ____ **Speech:** Within normal limits? Yes ____ No ____

Developmental Screen: Age Appropriate? (e.g., jumps in place, knows own name, rides a tricycle) Yes ____ No ____

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (Pediatric Symptom Checklist, parental interview, observation) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test
Yes _____ No _____
(perform if at risk)

SCREENINGS:

Blood Lead Test
Yes _____ No _____
(Perform at 36-72 mo of age if not previously done)

ADDITIONAL LABS ORDERED:

Hgb/Hct Yes ____ No ____
Urinalysis Yes ____ No ____
Other:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** _____ **Deferred?** _____

Given today? **Hep B** _____ **Varicella** _____ **PCV** _____ **Hep A** _____ **Influenza** _____ **Other** _____

ANTICIPATORY GUIDANCE

- Drowning prevention
- Sun Safety
- Car Seat
- Sport helmet use
- Nutrition/exercise
- Dental caries prevention
- Toilet training
- Passive smoke
- Reading/preschool
- Discipline
- Social interaction
- Family involvement
- Next appt./transportation?

REFERRALS:

Behavioral _____ **Dental** _____ **Nutritional** _____ **Speech** _____ **DDD** _____ **ALTCS** _____ **CRS** _____

WIC _____ **Specialty** _____ **Developmental** _____ **Other** _____

Clinician Name (print): | Clinician Signature: | Yes _____ No _____ See Additional/Supervisory Note?

Revised January 1, 2004